RxConnector is a publication of the North Dakota Insurance Department's Prescription Connection program.

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RxConnector

HealthWell offers assistance for certain people with insurance

The HealthWell Foundation offers a program that provides financial assistance to eligible individuals to cover coinsurance, copayments, health care premiums and deductibles for certain treatments. Also, for those who are eligible for health insurance, but cannot afford the insurance premium, the program may be able to help by paying some or all of the medical portion of insurance premiums.

A patient must be treated for a specific disease for which funding is available and has insurance that covers the treatment for this disease. Call for the most recent medications as the list is subject to change.

Applicants with insurance are eligible. The Foundation considers an individual's financial, medical and insurance situation when determining who is eligible for assistance. Families with incomes below 400 percent of the Federal Poverty Level may qualify. Cost of living in a particular city or state is also taken into account. Medication must be used for medically appropriate condition. The patient must also reside in the U.S.

Anyone can call to get the application sent out or it may be completed online. The application is sent out or it may be completed online. The patient is notified of eligibility for the program. The estimated timeline is 3-5 business days.

Two methods of application are:

- Online. To get started, click here.
- By phone. Call (800) 675-8416.

For more information, go to HealthWell's website at www.healthwellfoundation.org/what-we-do.html.

(HealthWell)

Hospital Compare website offers new data about hospital acquired conditions

For the first time, Medicare patients can see how often hospitals report serious conditions that develop during an inpatient hospital stay and possibly harm patients with important new data about the safety of care available in America's hospitals added today to the Centers for Medicare & Medicaid Services' (CMS) Hospital Compare website.

The Hospital Compare website can be accessed at: www.HealthCare.gov/compare.

(CMS)

North Dakota Insurance Department
PROTECTING THE PUBLIC GOOD
Prescription Connection

1.888.575.6611 701.328.2440
insurance@nd.gov www.nd.gov/ndins

Dear friends,

This newsletter is designed to keep you up to date about the Prescription Connection for North Dakota program and to keep you in the know about the various prescription assistance programs that are available. From time to time, we may also include other items of interest related to Medicare and the State Health Insurance Counseling (SHIC) program.

As always, thank you so much for all that you do for the Prescription Connection program. Without your help, our work would be that much harder. Your efforts are valued and appreciated.

If you have items of interest that you think should be included in this newsletter, we would love to hear about them. Please contact Sharon St. Aubin at sstaubin@nd.gov or call her at 1.888.575.6611.

Adam Hamm
Insurance Commissioner

Prescription drug plan formulary changes

Although most people with Medicare can only change their drug plans during fall annual enrollment period (Oct. 15 to Dec. 7 in 2011), the drug plans can change their formularies more often. There is guidance on when plans can make these changes to their formularies and what steps they must take if they decide to make those changes during the plan year.

Plans cannot change their formularies during the open enrollment period and for the first 60 days of the calendar year. The exception to this is if the prescription drug is declared unsafe by the Food and Drug Administration (FDA).

After the first 60 days of the year, there are two types of changes that plans can make. The two types of changes are maintenance and non-maintenance changes. Maintenance changes include generic substitutions and adding utilization management tools.

The plans are required to send notices to beneficiaries who are impacted by these changes. They are either requires to give 60 days notice or to provide a 60 day transition fill.

An example of a non-maintenance change would be to add step therapy as a requirement for a drug that does not already require step therapy. Such a change needs to be approved by CMS. For these non-maintenance changes, people who already take the drug will be protected against any changes for the remainder of the calendar year. This means they can get their drug until the end of the year. For non-maintenance changes, the plan needs to wait to hear from CMS before implementing the change.

For more information about the guidelines for drug plans changing their formularies, see Chapter 6, section 30.3 of the Medicare Prescription Drug Benefit Manual. https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Chapter6.pdf

(The Medicare Counselor)

Medicare coverage of inpatient mental health services

Medicare helps pay for inpatient mental health services in either psychiatric hospitals (hospitals that only treat mental health patients) or in general hospitals. Your doctor will determine which hospital setting you need.

If you receive care in a psychiatric hospital, Medicare helps pay for up to 190 days of inpatient care in your lifetime. After you have reached that limit, Medicare may help pay for mental health care at a general hospital.
Your out-of-pocket costs are the same in a psychiatric hospital as they are in any hospital.
If you enter a psychiatric hospital within 60 days of being an inpatient at a different hospital, you are in the same benefit period and do not have to pay the deductible again. A benefit period begins the day you start getting inpatient care and ends when you've been out of the hospital or skilled nursing facility for 60 days in a row.

Question: I have Alzheimer's disease and Medicare has been refusing to pay for my care. Is there anything I can do?

Answer: Yes, you should appeal. In 2001, Medicare notified the companies that process Medicare claims (regional carriers and intermediaries) that they should not make blanket denials of coverage of medical services for people with Alzheimer's disease or dementia. They should determine coverage for these services as they do for everyone with Medicare—based on the medical necessity. However, you may still experience inappropriate denials of treatment. Following are three situations in particular to watch out for:

1. **Denials of physical, speech and occupational therapy**

   Especially in the early stages of Alzheimer's disease, skilled physical, speech and occupational therapy may be appropriate if it will help prevent or minimize any deterioration of your capabilities.

   If your doctor thinks that therapy can help you, Medicare should not refuse to pay based solely on a diagnosis of dementia or Alzheimer's disease, or on the rationale that your condition cannot improve.

2. **Denials of mental health treatment**

   People with Alzheimer's disease and dementia often suffer from related mental health conditions, such as depression and agitation. These conditions can be helped with treatments like psychotherapy and behavior management but you may be inappropriately denied coverage for these treatments if you have Alzheimer's or dementia.

   However, if your doctor thinks you can benefit from psychiatric or mental health services, Medicare should not deny your claim for these services based solely on your diagnosis of dementia or Alzheimer's disease and under the assumption that you will not benefit from the treatment. In addition, family counseling should be covered when it is needed to help your loved ones learn how to manage your condition.

(Medicare Interactive)

FDA-approved drugs

The following database contains a listing of drugs approved by the Food and Drug Administration (FDA) for sale in the United States.

Cardiology/vascular diseases
Edarbi (azilsartan medoxomil); Takeda; For the treatment of hypertension, Approved February 2011

Dermatology/plastic surgery
Gralise (gabapentin); Abbott; For the treatment of postherpetic neuralgia, Approved February 2011

Yervoy (ipilimumab); Bristol-Myers Squibb; For the treatment of metastatic melanoma, Approved March 2011

Immunology/infectious diseases
Benlysta (belimumab); Human Genome Sciences; For the treatment of systemic lupus erythematosus, Approved March 2011

Daliresp (roflumilast); Forest Pharmaceuticals; For the treatment of chronic obstructive pulmonary disease, Approved February 2011

Gralise (gabapentin); Abbott; For the treatment of postherpetic neuralgia, Approved February 2011

Neurology
Abstral (fentanyl sublingual tablets); ProStrakan; For the treatment of breakthrough cancer pain in opioid-tolerant patients, Approved January 2011

Gralise (gabapentin); Abbott; For the treatment of postherpetic neuralgia, Approved February 2011

Viibryd (vilazodone hydrochloride); Clinical Data; For the treatment of major depressive disorder, Approved January 2011

Obstetrics/gynecology
Makena (hydroxyprogesterone caproate injection); Hologic; For the prevention of risk of preterm birth, Approved February 2011

Oncology
Abstral (fentanyl sublingual tablets); ProStrakan; For the treatment of breakthrough cancer pain in opioid-tolerant patients, Approved January 2011

Yervoy (ipilimumab); Bristol-Myers Squibb; For the treatment of metastatic melanoma, Approved March 2011

Pediatrics/neonatology
Daliresp (roflumilast); Forest Pharmaceuticals; For the treatment of chronic obstructive pulmonary disease, Approved February 2011

Psychiatry/psychology
Viibryd (vilazodone hydrochloride); Clinical Data; For the treatment of major depressive disorder, Approved January 2011

Pulmonary/respiratory diseases
Daliresp (roflumilast); Forest Pharmaceuticals; For the treatment of chronic obstructive pulmonary disease, Approved February 2011

(FDA)

Medicare vaccination/immunization reminder

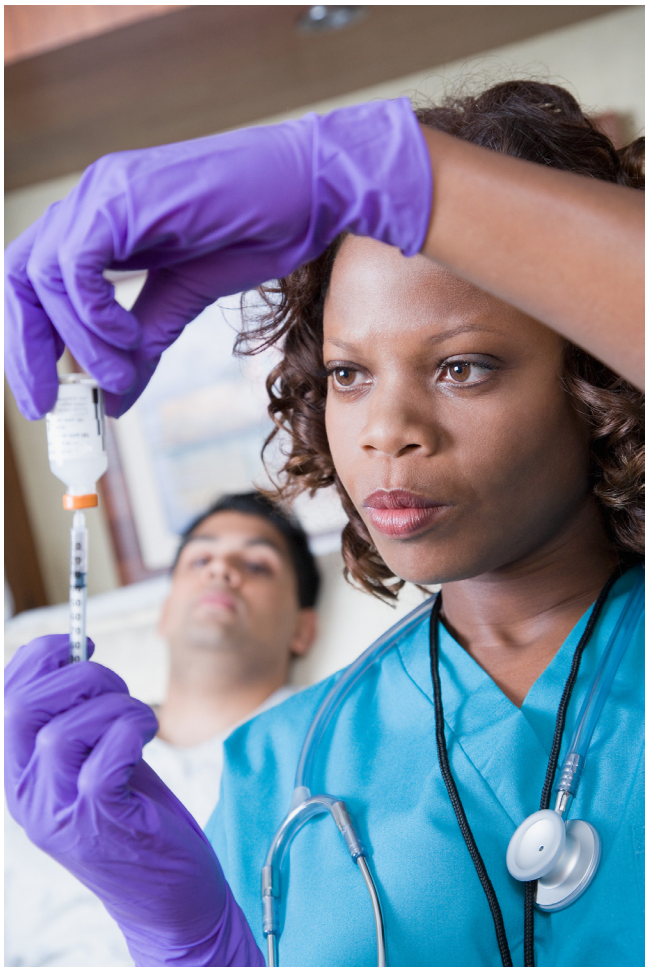
Medicare covers some vaccines and immunizations. The way Medicare covers them depends on which vaccine you need.

Your Medicare health coverage (Part B) will cover vaccines to prevent:

- Influenza (the flu);
  - Currently, the seasonal flu shot includes both a seasonal flu shot and an H1N1 (swine flu) vaccination.
- Pneumonia; and
- Hepatitis B (if you are at medium to high risk).

Part B will cover other immunizations only if you have been exposed to a disease or condition. For example, if you step on a rusty nail, Medicare will cover a tetanus shot; if you are bitten by a dog, Medicare will cover your rabies shots.

If you have a Medicare prescription drug plan (Part D), you may be able to get coverage for other types of vaccines, such as the vaccine for shingles (herpes zoster). Any commercially available vaccine that is not covered by Part B should be covered by your Medicare prescription drug plan. Your Part D plan will pay for the vaccination itself and for your doctor or other health care provider to give you the shot (administration). However, you will need to make sure you follow your particular plan's rules in order for the vaccine to be covered. Before you get a vaccination, you should check coverage rules with your Part D plan and see where you should get your shot so that it will be covered for you at the lowest cost.



Learn more about Medicare coverage of vaccines and immunizations at www.MedicareInteractive.org.

Federal Pre-Existing Condition Insurance Plan (PCIP)

Adults who have a pre-existing condition or have been denied coverage because of a health condition, and who have been uninsured for a minimum of six months before applying, qualify for the federal Pre-Existing Condition Insurance Plan (PCIP) in their state.

To learn more and to apply, go to www.pcip.gov.

(AARP North Dakota)

Medicare rise could mean no Social Security COLA

Millions of retired and disabled people in the United States had better brace for another year with no increase in Social Security payments.

The government is projecting a slight cost-of-living adjustment for Social Security benefits next year, the first increase since 2009. But for most beneficiaries, rising Medicare premiums threaten to wipe out any increase in payments, leaving them without a raise for a third straight year.

About 45 million people—one in seven in the country—receive both Medicare and Social Security. By law, beneficiaries have their Medicare Part B premiums, which cover doctor visits, deducted from their Social Security payments each month.

When Medicare premiums rise more than Social Security payments, millions of people living on fixed incomes don't get raises. On the other hand, most don't get pay cuts, either, because a hold-harmless provision prevents higher Part B premiums from reducing Social Security payments for most people.

David Certner of AARP estimates that as many as three-fourths of beneficiaries will have their entire Social Security increase swallowed by rising Medicare premiums next year.

(Associated Press)

Incorrect billing for Medicare services

Medicare uses treatment and diagnosis codes to process medical claims. Medicare may incorrectly deny or reduce payment for medically-necessary services if your doctor has submitted a claim to Medicare with the wrong codes.

- If you received care for a condition unrelated to your dementia or Alzheimer's disease, like a broken hip, your doctor should submit a claim with a primary diagnosis code for that condition. If your doctor submits a claim with a primary diagnosis code of dementia or Alzheimer's, Medicare may deny any medical claims for the care you received. If you had hip replacement surgery, your doctor should use the proper "hip replacement" code as a primary diagnosis, not the diagnosis code for "dementia" or "Alzheimer's disease."
- Medicare generally pays 80 percent for a covered medical service and 55 percent for a covered mental health service. However, if your doctor submits a claim with a primary diagnosis code for a mental health condition such as "pre-senile dementia" instead of the medical service you received, Medicare may mistakenly cover the service as a mental health condition at 55 percent instead of 80 percent for a medical condition.

If your doctor has submitted an incorrect diagnosis or treatment code, you should ask your doctor to resubmit your claim with the correct codes. You may also need to appeal Medicare's decision.

(Medicare Interactive)